REGISTRATION OF ADDITIONAL DEPENDANTS

PULA MEDICAL AID FUND Administered by Associated Fund Administrators Botswana (Pty) Ltd.
Gaborone: AFA House • Plot 61918 • P O Box 1212 • Gaborone • Botswana • Telephone: (+267) 365 0555 (Call center) / 365 0500 (Reception) • Fax: (+267) 395 1165
Francistown Branch: Plot 32397 • Office 26 Sunshine Plaza Francistown • P O Box 323 Francistown Botswana • Telephone : (+267) 241 2290 / 2390
www.pulamed.co.bw

***please complete in block letters, tick appropriate blocks unless otherwise indicated**

About yourself (principal member)

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Title ☐ Initials ☐ Surname ☐

First name(s) ☐ Sex M ☐ F ☐ Date of birth ☐

Membership No ☐

Occupation ☐

ID or passport number ☐ Country of Issue ☐

Basic Salary P ☐

Cell ☐ Tel (H) ☐ Tel (W) ☐ Fax ☐

Email ☐

Postal Address ☐ Village/Town ☐ Physical Address ☐

About your spouse (only complete if adding spouse)

Title ☐ Initials ☐ Surname ☐

First name(s) ☐ Sex M ☐ F ☐ Date of birth ☐

Employer ☐

ID or passport number ☐ Country of issue ☐

Cell ☐ Tel (H) ☐ Tel (W) ☐

Email ☐

*attach copies of marriage certificate and spouse ID

About your dependants (only complete if adding child dependants)

FAMILY MEMBERS TO BE COVERED

First Names & Surname(s) ***Attach child's birth certificate.**	Birth Dates	Gender	Identity Number/Birth Certificate or Passport Number
		M F	
		M F	
		M F	
		M F	
		M F	
		M F	
		M F	

Date of joining the Fund ☐

Name of previous Medical Fund ☐

Date of previous membership: From: ☐ To: ☐

*if any, attach certificate of membership

IMPORTANT
Failure to complete all information and attached document required **will** delay processing of membership. Failure to disclose material information or provision of incorrect information **can** result in the immediate cancellation of membership.

Signature of Member: _____ Date: _____

Your employment details

Name of Employer

Occupation

Date of employment

Employer warranty

We warrant that the main applicant detailed in the first section of this application form is an employee of our organisation.
Pula Medical Aid Fund may bill us for the amount due for this member in the same way as it does for our other employees with Pula Medical Aid Fund

Name

Designation

Email

Telephone

Postal Address

EMPLOYER'S STAMP

Authorised signatory_____ Signature of the Principal Member:_____

*** please complete the Medical History and General Health information form**

MEDICAL HISTORY AND GENERAL HEALTH INFORMATION

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First Name _____ Surname _____ ID/Passport No: _____

Failure to disclose pre-existing conditions could limit and/or exclude certain benefits or result in termination of your membership.

OPTIONAL DISCLOSURE

Although you are not obliged to disclose the Chronic/HIV AIDS status of yourself or your dependant(s) on this form, you are required, in line with the Fund rules and underwriting criteria, to submit this form within 2 working days from the date you submit your membership application to clientservices@afa.co.bw or hand deliver at AFA House, Plot 61918, Showgrounds Office Park. We want to assure you that we treat this information with the strictest of confidence.

(please supply the required information by marking the relevant box with an ***X***)

		Yes	No
1.	Do any of your dependants use chronic medicine	Yes	No
2.	Disorders or problems with heart or cadiovascular system, e.g heart murmur, high blood pressure, high cholestrol, shortness of breath, palpitations, chest pains, angina, heart attack and/or other cardiac or blood disoders	Yes	No
3.	Respiratory or lung disorders, e.g tuberculosis, asthma, persistent cough or other breathing problems, emphysema, coughing up blood, cystic fibrosis, sinusitus or allergic rhinitis	Yes	No
4.	Disorders in the digestive system, stomach, gall bladder, pancrease or liver, e.g gastric or duodenal ulcers, heartburn, hiatus hernia, rectal bleeding, Crohn's disease, ulcerative colitis, irritable bowel syndrome, hepatitis, cirrhosis, liver failure or have you ever had a gastroscopy or colonoscopy?	Yes	No
5.	Diseases or disorders of the kidneys, bladder or reproductive organs, e.g abnomal urine tests, kidney stones, nephritis, prostatitis, bladder infections or sexually transmitted diseases.	Yes	No
6.	Disorder of the nervous system or brain, e.g epilepsy, stroke, multiple sclerosis, migraine,headaches, paralysis, Parkinson's disease, or have you or any of your dependants been advised to have an MRI or CT scan?	Yes	No
7.	Mental disorders, e.g depression, anxiety, panic attack, schizophrenia, eating disorders, attention deficit hyperactive disorder (ADHD), or post -traumatic stress disorder	Yes	No
8.	Ear, nose throat or eye disorders, eg defective vision, cataracts, glaucoma, retinitis, disorders of the cornea, hearing loss, ear discharge, otitis media or allergies	Yes	No
9.	Disorders or diseases of the skin, muscles, bones, joints, limbs or spine, e.g any skin rash, arthritis, gout, fibromyalgia, any back,neck,hip,knee or other joint trouble, multiple sclerosis, any joint problems, or replacements, acne, eczema or psoriasis?	Yes	No
10.	Diabetes, sugar in urine, thyroid or other glandular or blood disorders, e.g anaemia bleeding disorders, growth disorder, cushing's disease or Addison's disease	Yes	No
11.	Cancer, a growth or tumor of any kind including moles removed (malignant/benign)	Yes	No
12.	Are you or any of your dependants currently undergoing or anticipating any specialised dental, maxillofacial treatment?	Yes	No
13.	Have you or any of your dependant had any accidents (including motor vehicle accidents)?	Yes	No
14.	Are you or any of your dependants taking ongoing medicine for any condition no listed in any other question?	Yes	No
15.	Have you or any of your dependants had any surgical procedure?	Yes	No
16.	Are you or any of your dependants awaiting or planning any operation or admission to any hospital in the next 12 months	Yes	No
17.	Is there any other condition or symptom, which is not detailed in any other question, for which medical advice, diagnosis, care or treatment has already been recommended or received, or could potentially result in a medical claim within the next 12 months?	Yes	No
18.	Gynaecological disorders, e.g abnormal pap smear or mammogram, endometriosis, ovarian cysts, fibroids, infertility, disorders of the cervix, menstrual disorders or any abnormalities of pregnancy	Yes	No
19.	Are you or any of your dependants pregnant? If so, what is the expected date of delivery? Date: _____	Yes	No

Disclaimer

Please note that the following exclusions and waiting periods may be applicable as prescribed by the Fund rules, pre-existing conditions; 2 years, limited dentistry; 12 months, 9 months maternity; and 3 months waiting period for an infant child registered after 30 days of birth or adoption.

If your answer was yes to any of the above questions, please provide full particulars in the space below. Please use a separate sheet of paper if the space provided is not enough. **Please also note that members with chronic conditions have to register with the Managed Care Department.**

Name of the person suffering from the illness				
Question number				
Illness or condition				
Date on which illness began				
Date of last occurance				
Name of treating Doctor				
Doctor's contact details				
Treatment recommended (medicine, etc.)				
Treatment from (date)				
Treatment until (date)				

Declaration

Failure to disclose material information is fraud. The provision of false, incorrect or incomplete information can result in the immediate cancellation of your membership.

I the undersigned, hereby make application to the Administrator to be admitted as a member of the Fund, and if admitted I agree to abide by the Rules of the Fund. I declare that any false statement in the above questionnaire or the non - disclosure of any material information will render my membership null and void. I warrant that the above answers are true, correct and complete in every respect. I hereby authorise my employer to deduct from my salary each month the specified contribution and indebtedness to the Fund and pay the Fund on my behalf. I confirm that I am employed by the Employer in a full time capacity. I undertake to Advise the Administrator of any change in my state of health or that of my dependents which occurs prior to my receiving written acceptance of this application.

Signature of Member:_____ Date:_____